# Bioenergetic Self-Care for Therapists

## Between openness and boundary setting

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Abstract

In this paper I will present neurobiological findings on the somatic effects of resonance phenomena, empirical results on the respective occupational risks of therapists, and bioenergetic concepts and techniques regarding the subject of self-care. While I was thrilled to have described the phenomena of somatic resonance in the late 1990s and it's potential for work with embodied countertransference in the therapeutic process, the discovery of mirror neurons a short time later validated these exciting phenomena on the neurobiological level. Since then I have also immersed myself onto the flip side of empathy. We as resonating therapists are in danger of losing our own living vibration, possibly even becoming sick. Bioenergetic exercises can - with a correspondingly modified non-clinical focus - be very helpful for the self-care of therapists. The illustrations (cartoons) hopefully bring some humor to the presentation of this important and hitherto neglected topic.

(INSERT GERMAN ABSTRACT) (need Italian, Sp, Fr abstracts too)

In diesem Beitrag stelle ich neurobiologische Erkenntnisse zu den somatischen Auswirkungen von Spiegelungsphänomenen, empirische Ergebnisse zu Berufsrisiken von Therapeuten sowie bioenergetische Konzepte und Techniken im Hinblick auf das Thema Selbstfürsorge dar. Während ich Ende der 90ger Jahre begeistert die Phänomene der somatischen Resonanz und ihr Potential für die Arbeit mit der verkörperten Gegenübertragung im therapeutischen Prozess beschrieben habe, die Entdeckung der Spiegelneurone kurze Zeit später diese spannenden Phänomene neurobiologisch validierte, beschäftigt mich seither auch die Kehrseite der Empathie. Wir sind als mitschwingende Therapeuten in Gefahr, unsere eigene lebendige Schwingung zu verlieren, eventuell sogar krank zu werden. Bioenergetische Übungen können – mit entsprechend verändertem nicht-klinischen Fokus – sehr hilfreich sein für die Selbstfürsorge von Therapeuten. Die Illustrationen (Cartoons) bringen hoffentlich etwas Humor in die Darstellung dieses wichtigen und bislang vernachlässigten Themas.

## 1. Introduction

To be in living contact with our therapist body, our resonance skills and grounded presence are the basis for any successful work with patients. Our ability to vibrate (resonance) and set boundaries, from a bioenergetic perspective, are both connected to the breath and voice as well as muscle motility.

"People, whose body is so rigid and paralyzed, that it hardly pulses or just pulses a little, lack empathy. If our body is alive, then we are sensitive to other people and their feelings and we also feel more love and pleasure" (cf. Lowen 1992, p. 388).

For 60 years, bioenergetic analysis - in the tradition of *Wilhelm Reich* and *Alexander Lowen* – has not only awarded us an analytical understanding but a very appropriate methodology as well. These methodologies have been increasingly examined and supported in recent years by findings from the neurosciences.

The therapeutic relationship is, a priori and independent of the actually used physical interventions, an embodied relationship (Reich spoke of the "functional identity of psyche and soma"). This means that our therapist-body represents - apart from technique – both the medium and the agent for the therapeutic process, and is therefore, in terms of self-care as well, the most important "instrument" to be cultivated.

The physical aspect of empathy, the "sympathetic vibration," is essential to the therapeutic process: yet, because of the intensity of this resonance, we are nevertheless at risk to develop a secondary traumatization if we do not dynamically take advantage of our own initiative and our ability to distance ourselves as an agent in the therapeutic process.

How can we sustain love and joy for our patients as well as for ourselves? The attempt to react empathetically with both body and soul to our patients has negative consequences for our emotional self-regulation if we get stuck being too receptive, externally motionless and without sufficient internal ability to set boundaries. Depending on what our patients bring to the sessions, we can become burdened and blocked in a variety of ways: we can experience, endure or act out fight or flight impulses in our relationship to our patients. When we are confronted with untold suffering, we can lapse into a state of shock. We can become ashamed, lose our sense of humor, freeze our heart-felt feelings, develop crazy fantasies, become frightened, afraid, annoyed, and lose touch with our loved ones at home and with our neighbors. Rarely is the efficacy of a therapy session measured by how it was for us - the therapist – how we felt afterwards as well if laughter was allowed during the session.

*In our work with patients, it is important to perform a balancing act between an emotional and physical openness (for relationship permeability and resonance and sake of our own health) as well as simultaneously create a protective boundary from any overflowing and damaging effects on the part of patients.*

In terms of bioenergetic self-care, we need - beyond the basic breathing techniques and grounding - a clear understanding of the effects of specific bioenergetic techniques, particularly those that help to energize us (instead of "discharging" us) and help improve our containment and our individual boundaries (cf. Klopstech 2011). We can find help in the bioenergetic differentiation between the concepts of "charge" and "discharge", as we have learned to do regarding the structural organization (early disturbance vs. oedipal) of patients. Bioenergetic self-care requires that we modify these well-known bioenergetic techniques a little and direct our attention to charging/containing and boundary building (cf. Shapiro 2006, 2008) - or simply combining these familiar techniques with corresponding mental images and words to set our own boundaries.

## 2. Joys and *sorrows* of empathy - Neurobiological perspectives[1]

To begin, here are a few words about the joyful aspects of empathy without which we as communicative beings probably would hardly be able to survive and without which psychotherapy could not succeed. Empathy was initially defined on the cognitive level as an "ability to participate in the feelings and thoughts of another person" (cf. Kriz 1985, Körner 1998). The discovery of mirror neurons neurobiologically confirmed our experience of *somatic resonance* (cf. Heinrich-Clauer 1999, 2011). Empathy is a physical event. The mirror neurons cannot be turned on or off; they are not subject to arbitrary control. Observation of the behavior of another person automatically activates the same premotoric cell assemblies that the observed behavior is based on (cf. Rizzolatti et al. 1999). "The transfer of emotional information is […] intensified in resonating contexts." (Schore 2005, p. 403). It is a non-conscious, pre-reflexive mechanism used to uncover implicit intentions in the behavior of another person. It is not a mental process of identification (which tends to be more conscious). There is a brain in the gut that is involved in processing emotions and even works faster than the centers in the brain stem. Neuron cells exist in the heart (cf. Gershon, 1998; Siegel, 2011). Friendly eye contact, vocal differentiation and any contact within the context of a trusting relationship bring about a regulation of autonomic arousal as well as a regulation of the pain threshold. This is done by tonifying the ventral vagus and oxytocin secretion (cf. Porges, 2010; Moberg 2003).

This neurobiological evidence was very welcomed by all body psychotherapists regarding the implicit part of the therapeutic encounter. It corresponded to clinical experience that changing embodied relational statements (resonance) defined the therapeutic process and that the facial expression, gestures, posture, eye expressions, voice, breathing rhythms and body tone of the therapist and the patient influence each other (cf. Buti Zaccagnini 2011). Moreover, the psychotherapist uses her own somatosensory processes to perceive those of her patient and the psychotherapist is psychobiologically in tune with his patients and thus becomes the interactive regulator of the patient's regulatory disorders (Tonella 2011, p 99).

Findings from neurobiology thus allow us to assume that empathy is "a contact by the right hemisphere of the patient with the right hemisphere of the therapist" or is to be understood as "a conversation between two limbic systems" (cf. Schore 2002, 2003, 2005; Lewis 2004, 2005). We can also say that empathy means "to feel the physical phenomena and sensations of the clients in our own body" (cf. Clauer 2003, p. 97) according to Harold Searles.

- **(INSERT FIG 1) Here Fig.** "Therapy begins if the therapist feels what the patient is feeling" (paraphrased from Searles)[2]

[1] (cf. More information on the Integration of neurobiological concepts in Bioenergetic Analysis, see Klopstech 2005, 2011; Koemeda-Lutz 2012)

[2] For this and all following illustrations in this paper: © Vita Heinrich-Clauer, Graphics: Tanja Aranovych, Graz, www.tanjaaranovych.com

Now on the sorrows of empathy: even 35 years ago Lowen had, in his own way, indicated that a therapeutic situation does not necessarily have to be a pleasurable one if our counterpart has problems expressing emotion and we are subjected to it.

"Conversation, to take another example, is one of the common pleasures of life, but not all conversation is pleasurable. The stutterer finds talking painful, and the listener is equally pained. Persons who are inhibited in expressing feeling are not good conversationalists. Nothing is more boring than to listen to a person talk in a monotone without feeling. We enjoy a conversation when there is a communication of feeling. We have pleasure in expressing our feelings, and we respond pleasurably to another person's expression of feeling. The voice, like the body, is a medium through which feeling flows, and when this flow occurs in an easy and rhythmic manner, it is a pleasure both to the speaker and listener." (Lowen 1975, p.29/30).

What helps the empathic therapist in the picture to breathe and stay secure in her own rhythm? Certainly not sitting, holding her breath or going with the flow of tears leaking out! Sitting negatively affects metabolic activity. It is conducive to the health of the therapist if she wishes to move about - inside and outside the therapeutic situation. When we (moderately) move, oxygen exchange is in equilibrium. Our intercostal muscles and diaphragm relax and we breathe better. In the long run it may not be that healthy to sit on a chair, reflect the pain of our patients and, in a relatively breathless and motionless manner, only expose ourselves to their pathological relational patterns.

As a therapist I need to ground myself (to stay in contact with reality), have the ability to set boundaries and maintain a lot of emotional retention force (containment) for the patient's subconscious and intolerable feelings, but not in the sense of a motionless "container." A better comparison is that of a resonating body with a lively, moving and tonifying outer shell/membrane. Seen this way, my sigh and exhalation - accompanied by a sympathetic look – would already be the answer to the painfulness of a patient's experience, without having to utter a word. And my next inhalation as a therapist would represent a first action to help myself feel better. The larger the amplitude of my breath, the more likely can I achieve the full spectrum of emotional resonance and living expression - but the more likely do I feel my physical boundaries and the limits of the burden. Movement too could lead out of the shared depression. It is a requirement that the therapist not only endures the heated emotions of her patients both physically and emotionally, but remains lively in the process and is grounded enough to set boundaries when it exceeds her holding capacity.
In Bioenergetic Analysis, we respond to our patients, regarding our interaction with and towards them, with our changing body positions, i.e. we make ourselves available in an interactive, cooperative way - and not simply mirror this from a seated position (cf. Heinrich-Clauer 2009, pp. 36 ff.)

Some (MRI-based) neurobiological research results should now be mentioned which appear extremely important regarding the non-conscious, not articulated painful influences– here, in the middle phase of the therapy - that may detrimentally influence a psychotherapist within the therapeutic relationship:

When we look at a person's face that shows a disgusted facial expression, then the same neuronal structures (anterior cingulum) are activated as when we feel aversion or disgust from smelling or inhaling something unpleasant (cf. Siegel, 2011).

Social and physical systems of pain perception and processing are connected. Insults and hurt feelings are experienced the same way as physical sensations of pain (Bauer 2011). Being excluded, neglected, degraded - hurts the heart like a knife (cf. Siegel, 2011).

IIn an empirical study of couples, called, "*Lovers share their pain",* neurologists from University College in London discovered that a neurophysiologically measurable indication of empathy could be observed in one partner whenever the other experienced pain. If the partner knew that her partner was currently receiving an electric shock, then the same brain regions that control *emotional* responses to pain (e.g. sadness, arousal, fright) responded as if she had received the shock stimulus herself. Only that region of the brain which registers *physical* pain was stimulated when she received the electrical stimulus herself. The emotional processing of the partner was always stimulated even if the partner's face was not visible in the study, but only if the information was transmitted via display panels. The knowledge and mental picture about the partner's pain are enough to activate even those regions of the brain that control emotional responses to pain (cf. Science 2004, Vol. 303, p 1157).

Neurobiological research, in its research design, is still far from the kind of complexity that we would need in order to elucidate the process of unconscious interaction during a therapy session. The mirror neurons partially explain some of these observations, but not the whole complexity of the relational events and somatic resonance, such as sensory perceptions of cold/heat, heaviness/lightness, contraction/expansion, etc.

C.G. Jung and his concept of "infection" already had a constructive and process-oriented understanding of the right-brained resonance between patient and therapist (cf. Jung 2011 paraphrased): "The therapist infects himself with the suffering of the patient."

With this assumption, Jung was not explicitly exploring physical mirroring and resonance, but had expressed something like a relational perspective of countertransference.

- **Here insert Fig.** "The therapist identifies himself with the suffering of the patient." (C.G. Jung)

The first reaction of the therapist may be shock at the patient's symptoms, as in, "Oh my goodness, there's no way he should be that fat."(or), "For God's sake, there's no way I want to have a body like that!" The spine of the therapist stiffens accordingly as in the previous illustration. His face (eyes, forehead, mouth) conveys that it does not want to eat. At the same time, it has already trapped him via contact with the hands, looking, and feeling. The therapist does not consciously admit it, but his body recognizes the imprisonment of his reaction to the patient.

How are we influenced by our depressive, exasperated, anguished, or disparaging patients? And how do we overcome these "infections"? How can we protect ourselves from the harmful

influences of patients when we are simultaneously trying to feel as open as possible? One way out is the work with the embodied countertransference as a catalyst for the scenes and techniques available to us.

The mental image of a solution then emerges out of the self-defensive posture against this "infection": "The self-healing attempts of therapists promote the therapy process." (paraphrased C.G. Jung 2011).

- **Here INSERT NEXT Fig.** "The therapist's self-healing attempts start the therapy process" (CG Jung)

With this vision of the slender patient, he mentally gives it back to him and will certainly look for ways *not* to understand why the patient can be so fat. On the path to the liberating vision of the more slender, more agile patient, the therapist will need to develop many physical initiatives to extract herself from the infection. The infection as such, however, can also be included in the interaction with the patient on the concrete physical level.

This concept differs from concepts which primarily think of therapists as "containers" for the feelings of their patients in order to "hold" their not-held, not bearable, not consciously perceived feelings for them. If this holding takes on too much of a quality of "enduring" and too little respiration and pulsation are present, then the effects tend to be harmful to the soul and body of the therapist and, of course, detrimental to the therapy process. Our resonance animates the therapeutic process if we make it available, and can be used as a catalyst and generator for new patterns of physical movement, new means of experience and expression by patients so that the process can be more playful and flowing *(cf. Heinrich 1997, 1999, 2001; Clauer 2003; Heinrich-Clauer 2014).* The therapist's breathing is the central key to perceiving these (see Downing, 1996, pp. 322f). It is possible to put that which was felt during contact into descriptive words and carefully communicate this or perhaps reflect it non-verbally.

- **Here Fig.** "The therapist's breathing is the key for perceiving countertransference" (G. Downing)

A patient without awareness of his fear and need for love can cause the therapist to hold her breath and become terrified even by his physical expansion and dominance alone. In this case, a resuscitation of the therapist would be possible from the indication of her awareness to hold her breath and become terrified, together with a question directed towards the patient, asking if he had experienced this kind of inner attitude from his past. If the patient exhibits *no amnesia* from his own traumatic experiences, then these are often reported without emotion or with a smile so that I, as a therapist, experience somatic resonance phenomena (such as loss of ground contact, freeze, fright, reduced breathing, nausea, etc.) and in this way receive references to past emotional events. Once the patients are activated and enlivened we too have a chance to feel more alive.

## 3. Occupational risks in psychotherapy

If we feel obliged to maintain an empathic attitude and dare not perform any dynamic, bioenergetic interventions for our own safety and for our own well-being during the therapy process and in the presence of the patient, then this attitude can be dangerous.

### 3.1 Psychological risks: Suppression of Anger, Depression, Burnout

"To resist harmful influences, is also a question of vitality: the exhausted is tempted by the vice" (Robert Musil in "The Man without Qualities.")

- **INSERT next Here Fig**. "The exhausted is tempted by the vice" (Musil)

This therapist has obviously lost her ability to set herself boundaries, ground herself and demonstrate self-control in her contact with her patients. Spatial-temporal boundaries seem necessary as well. This kind of a dissolution of boundaries and lack of resilience can manifest itself in such symptoms as a difficulty to meet deadlines, fatigue, a lack of energy, a feeling of being flooded by the issues of the patient, thinking about the stories of the patients at home, or our patients controlling the course of the session.

The classic burnout symptoms mentioned in the relevant literature are (cf. Fengler 1994):

- Emotional exhaustion - depression (low energy levels)
- Low personal potential (sense of futility, inefficiency)
- Depersonalization and loss of empathy (cynical attitude towards patients)

The following aspects are considered to promote burnout in professional and private life:

- Imbalance between effort and reward
- High demands with minimal influence
- Endangered work-life balance
- Narcissistic regulation at risk: great need for recognition combined with a low possibility of reward

Besides financial remuneration, we need a sense of self-efficacy and "reward" from our work. Until the first improvements of the often stubborn and violent symptoms - or even positive life changes - can come to fruition in patients, our psychotherapeutic work is often an exercise in patience. Work with resistance and negativity in the relationship between therapist and patient, which is required during psychodynamic and bioenergetic therapy, often lets us fall into despair rather than feel successful, especially in the middle phase of a long-term psychotherapy.

Thus, the psychotherapeutic work per se already meets some of the above mentioned criteria for burnout-promoting contextual conditions. Add to that "patient-client confidentiality", which is the obligation to protect the patient and to keep silent about the contents of the therapy to the outside world. This requirement conflicts with our need to be seen in our social environment and be recognized for our work. The occupational hazard of our profession has

hardly been explored on a systematic level, but has received increasing attention lately (see the many articles and training courses advertised in trade journals in recent years) and was discussed in a German study on the quality of life of psychotherapists.

Among the occupational group of medical doctors, both psychiatrists and anesthesiologists have the highest suicide rate. Comparatively high rates of suicide have also been observed with psychologists. This professional occupation spent with people who denigrate, deny, are addicts, have destructive relationships, see life negatively, show symptoms of depression, hatred, anger, fear, and perversion, can be very distressing and reduce our quality of life. In borderline patients, we sometimes experience a constant questioning and threat to our limits and integrity.

The constant emotional overload - from narcissistic motives - can make one sick and cause symptoms of tension, stress, exhaustion, fatigue, sleep disorders, burn-out, and tobacco or drug abuse. The relationship with our partner, children friends and family may suffer because our willingness to open up to the interests of other persons is reduced in our private lives. In general, any joie de vivre, confidence, and fun can be dampened. In addition to symptoms of depression, we can also develop aggressive feelings towards our patients, including disinterest, a cynical or ironic distance, objectification of the contact, hostility, impatience, anger, and boredom.

The patient simply becomes an object for counseling or therapy, whereby the technique that comes into question for this "case" is considered solely for professional reasons with no real empathy and loving attitude. The unconscious hostile countertransference reactions can lead to sadistic, power-oriented dealings with patients. These can be triggered not only by this distance and rejection of the patient but by their clinging, co-dependent and whining behavior as well (see Reimer, Jurkat et al 2005;. Deutsches Ärtzeblatt 11, 2003; Niedersächsiches Ärzteblatt 7, 2003).

From our perspective, in terms of the self-care of therapists, it is crucial that we acquire a temporal-spatial distance from our patients.

A positive image of distance in the relationship (individuation and separation) and autonomy (independence in the relationship) helps to limit any feelings of guilt we may have. Bioenergetic exercises for at home (in the interim) can be considered as *transitional objects* for the patient and help to maintain the therapeutic relationship.

"The physical exercises for grounding also allow the patient to develop himself positively regardless of the presence of a therapist. In doing so, on a developmental psychological level, these exercises build on the inexhaustible patience and joy exhibited by children to promote psychomotorical progress. Here we find the psychomotorical equivalents to the "ways out of fear and symbiosis" (Kast 1982) (see Oelmann 1996, p.131f). Furthermore,"When the symbiotic maelstrom is particularly large in the therapeutic relationship, encouragement to perform the exercises at home definitely promotes an autonomous detachment of the client from the therapist. The client can develop a feeling of how he can take steps towards personal growth independent from his contact with the therapist, even without her direct presence." (cf.

ibid, p 135).

We cannot fail to mention that it may be advisable for us therapists not only to lead these exercises or to provide recommendations on these to our patients, but to take this kind of transitional object with us to use for ourselves in our own spare time!

In this context I would like to point out research findings from infant research, which show that parents only respond 20-30% of the time truly empathically or properly tune to the infant. But securely attached children have parents (assuming they themselves are secure and well-tuned) who within two seconds at the most give their children freedom and space, to regulate this interaction as well as themselves and the parents and to release the tension (Tronick 1989). These implicit, non-verbal, two-second dyadic regulation systems operate throughout an entire life cycle. For the therapy situation, this means that we can allow ourselves a relaxed attitude if we can trust that we do not need to develop successful interventions 100% of the time to positively influence the self-regulation system of our patients. Less frequent phases of attentive and coordinated contact are enough to place these patients in a position to bring both their and our inner agitation back into balance through interaction.

- **INSERT Here Fig.** "Holiday plans of the therapist should be talked about in a timely manner."

A timely announcement makes it easier to be responsible to our own need for some rest and recovery within a relationship. Timely arrangements value our connection to the patient. Only if I deny the bonding quality of the therapeutic relationship - or don't even see it as a relationship, but as a working relationship determined by the technique - do I come up with the idea of considering divisions and distances between sessions as irrelevant.

Since the early 1950s, it has been known from psychosomatic research and the works of Alexander (cf. Alexander 1977) that particularly suppressed impulses of self-assertion or repressed hostile impulses have direct physiological effects and are the cause of somatic symptom formation. Since then, a variety of such psychosomatic connections have been proven on an empirical level. Worth mentioning in this context are the works of the emotion researcher Traue. These show that the suppression of emotional reactions, to neglect expressive behavior when communicating during simultaneous physiological arousal, which adversely influences the autonomous nervous system and the immune system, leads to psychosomatic symptoms. Whereas the expression of anger - especially when we show it to a person who has caused this trouble, lowers blood pressure and strengthens the immune system (cf. Traue et al 2005; Sonntag, 2003, p.48 ff). In this context, we as bioenergetic therapists wholeheartedly agree that the use of our active, expressive and emotionally-releasing interventions in patients can now be seen as having been empirically validated (Lowen 1978).

So far, all of these findings and empirical evidence have been made in reference to patients. It has not yet been addressed that these findings apply to us therapists just as much. It is not healthy to sit on a chair and expose ourselves either with constant concern or emotional distance and detachment (none of these two attitudes can be considered as healthy in the long

term) in a relatively motionless and expressionless way to the listlessness, anger and suffering, the depression or latent degradation of our patients!

For more than ten years, we have known about the neuroplasticity and nerve cell formation in the hippocampus, and the adaptability and learning ability of the brain. In the same way, we should not forget - in the fervor to create MRI-based "neurological maps" that display "locations" and their connecting paths - that this is rather a description of neurobiological and neurophysiological processes instead. It is mostly about reduced adaptability, about dysregulation - and not about "life-long" damage (van der Kolk, 2010, p 11). Luckily the idea of neuroplasticity is valid for life and for us psychotherapists as well because otherwise we too would also have to fear for our mind-body unity. If we turn to the painful experiences of our patients, which touch the limits of survivability, throughout our long professional lives while only experiencing their clarification and vitalization after a very long ordeal - or sometimes not at all, we may live at risk.

### 3.2 Narcissistic temptation

In order to be immune to narcissistic temptations and the misuse of an emotionally dominating position towards the patient, emotional stability and inner independence are an essential prerequisite. Because of our own stressful life situations, our need for contact and longing for recognition, we as therapists can become in danger of violating the personal boundaries and autonomy-related needs of our patients (see Schmidbauer 1999). In both the English and German literature on psychotherapists, reference is always made to the "wounded healer." This archetypal image is based on the idea that a healer must have been hurt herself in order to know how healing can succeed. At the same time, it is often alluded that therapists have often experienced trauma themselves and thus need help themselves, which is why their therapeutic job performance is impaired. However, there are indications that one's own problematic experiences in fact improve one’s ability to feel empathy and thus enhance the professionalism of therapists as well (Goldmann 2007).

Alexander Lowen has always talked about the fact that we cannot help our patients progress more than we ourselves have gained insight into our own past and have arrived at the solution of our own character-specific blockages: "The therapist cannot take the patient any further on the way to self-discovery and self-fulfillment than he has been himself." (Lowen 1993, p 8).

- **INSERT Here Fig**. "The therapist cannot take the patient any further on the way to self-discovery and self-fulfillment than he has been himself" (Lowen)

Most psychotherapeutic training programs are "case-oriented" and primarily convey methodological competence. The danger here is that a narcissistic position is thereby encouraged by focusing exclusively on the methodological issues and their supervision - the physical reality of the therapists in the repercussions of that reality on the process is neglected. Our own biographically conditioned vulnerabilities selectively shape our resonance

ability and influence the selection and modus of our interventions. Accordingly, the relationship offered by the therapist is always of a subjective nature – and not an objective one merely determined by the "case" or the chosen methodology. We hope to have learned a trained, differentiating, less conflictual and less defensive perception of body signals (embodied competence of the therapist).

The principle narcissistic issues, besides the depressive issues, certainly possess the greatest invitation of becoming virulent in the therapist herself within the therapeutic relationship - due to the asymmetric setting as well as some expectations on the part of patients. The therapist, thus, may possibly talk more about herself in order to obtain admiration or apply strong acting physical techniques (cf. Downing 1996, pp. 340f; Shapiro 2000).

Unconscious motives for the compensated narcissistic stance of therapists may - as with all other structures – lie in their general search for recognition, love, self-efficacy, etc. However, a particular motif here is also the therapist's search for admiration, superiority, ceding her own inner diminutive self to the patient, the shame of being human and incomplete, the lack of a secure footing (lower part of the body) and emphasizing the image of herself.

However, accepting Lowen's assignment to want to help patients "move forward" may already imply a narcissistic omnipotence fantasy as well!

Work on the self-regulation and self-monitoring of the patient - with the ultimate goal of his autonomy - per se, means that it is not we who "do" it. Rather, we trust in the body's self-healing powers and view ourselves as companions or catalysts. Especially the narcissistic seduction contained within the concept of "doing" should be particularly recognized as a threat in terms of a more directive technique like Bioenergetic Analysis.

## 4. Devotion to the therapist body: "instrument care"

The recommendations for psychotherapists to do something for their own health and well-being, avoid burn-out, joylessness and listlessness, are mainly focused on activities outside of the therapy sessions, such as the suggestion for self-therapy, supervision, peer supervision, sports, engage in wellness, yoga, singing, dancing, praying, meditating, or going on vacation. This distinction between physical activity *before and after the therapy sessions*, but sitting still during the sessions, fortunately is not part of Bioenergetic Analysis – and is also seldom in other forms of physical psychotherapy. Bioenergetic self-care is much more than subjecting yourself to self-analysis or case-oriented supervision. It means "instrument care", to revive yourself, to sustain your vibration, and always looking to stay grounded in order to prevent a depression or emotional detachment as a result of your workload. In doing so, the bioenergetic focus lies in our ability to ground ourselves (grounding), our breathing, our energy flow, as well as our limitations and emotional retention force (containment) - before, during and after a therapy session. Many exciting findings from neuro-immune and neuro-physiological research document, step by step, what we have already known for a long time

from clinical experience - that our body has enough regulatory systems to recover from stress if we give it the chance to do so (cf. Ehlert/Känel 2010; Schubert 2011).

4.1 Exercise, breathing, grounding

In epidemiological sports psychology research, a construct is currently being intensively discussed which calls itself "Sedantariness" ("sedentary lifestyle.") The results of these studies on "Sedantariness" revealed that people who do not engage in any sports activity at all, but only sit down a small amount of time during the day, lower their risk of premature death more than people who are even moderately physically active, but still sit the majority of the day. This speaks against any seated psychotherapy work!

"The sedentary lifestyle proves to be a significant risk factor especially for the incidence of metabolic diseases such as type 2 diabetes mellitus and coronary disease." Furthermore: "Sedantariness," according to current research, is a behavioral health risk that occurs relatively independent of physical inactivity." (Fuchs & Schlicht 2012, p.7).

There is also empirical evidence from studies on patients with chronic disease (arthritis, cancer, diabetes, cardiovascular) regarding the relationship between physical activity and well-being which stated that pure motoric training programs were significantly more effective than exclusive or complementary motivational/educational programs (cf. ibid, p.42).

By switching between phases of contraction and relaxation during physical activity, our muscles set free a type of neurotransmitter in the body called "endorphins." Endorphins cause pleasant sensations, a kind of natural "high," and can act as a mild analgesic - reducing pain in the body. Certain physical activities and pain experiences (e.g. the "runners high" or sports - such as climbing and paragliding, which are associated with flow-like experiences) can cause endorphins to be released, causing a feeling of happiness. This effect has now been medically confirmed albeit it is experienced very differently on an individual level.

To return to the plane of physical awareness, expression and body control, these results show, for example, that limiting the time allotted for speaking in therapy need not be a mechanistic, directive and contact-avoiding technique, as it is often emphasized by some analytical critics. Instead, doing so can at least improve the well-being and sensomotoric relationship of patients with psychosomatic disorders. That is, it may be advantageous for us therapists as well to simply motorically “work off” (not simply using verbal-affirmations or the imagination) the onerous experiences of our work with patients that are stored in our body! We as therapists of Bioenergetic Analysis enjoy the advantage of having flexible settings. As in other humanistic and physical psychotherapeutic methods, we can be physically active in a variety of ways during our work with patients. *Breathing* exercises and those that promote the *flow of energy*, which we may perform together with the patients, also enhances our self-perception and the motility of the muscles within this relationship. Likewise, our retention force and our ability to distance ourselves can grow with our ability to ground ourselves and practice deep breathing.

The reality-based principle of *grounding* (Lowen 1976) that is innate to Bioenergetic Analysis focuses our attention on the lower half of the body, on concrete grounding, on being rooted in

the here and now, which thus leads you away from an illusory self-concept (misjudgment and excessive demands). Grounding exercises stimulate our body awareness on the sensorimotor and proprioceptive levels (cf. Clauer, 2009; Siegel 2011). We can be sure of our own stance and stand point – both concretely and figuratively. The proprioceptive cells in our feet, hands, and face for example, provide us, together with the vestibular organ in our ears, with the information about our standing in the world as well as via our bones, muscles, tendons and ligaments (cf. Clauer 2009).

**Self-care exercises for therapists: Grounding**

(CAUTION: These exercises are provided for Bioenergetic therapists trained in the proper use of each one. Only use if you easily follow the directions and are clear in proper execution of each exercise. ed)

• Stand balancing your weight on one leg, while rolling the bottom of the foot of your other leg onto a small ball. You can hold onto a chair for better balance if needed. Use little rubber balls for foot (plantar) massage with an emphasis on the outer edges and the heel. This emphasizes the outer contour of the legs, hips and back, which changes self-perception from a receptive to an active mode. Control the pressure by how much weight you apply to each side. Exhale while giving weight down to your foot. Find a sound for expressing your pain. Switch feet.
• Pose like a runner at the starting line of a foot race: One leg in front of the other, knees bent, heels on the floor, and hands leaning down on either side of the front foot. Lean on the balls of both feet, as if ready to sprint forward. This exercise loosens the gluteal muscles and stretches the Achilles tendon. It promotes the feeling of being able to run away.
• Go into a forward bend, aka bendover, aka “Elephant”: hands and feet on the floor; head is relaxed, hips are high, weight mostly in legs. In this position make grimaces to the floor. Shake your head and think of unpleasant patients; make a "brrrrrr..." vocal sound.
• While in the elephant position, think of annoying patients who mistreat you. Use words like "Get lost!"; Say your words with strong affect.
• Move your hips from left to right, saying: "I value my sexuality, even if you do not value yours" (while thinking of sexually inhibited patients)
• Sit on your knees and lower legs, then place your head onto the (carpeted) floor. (aka the pose of the child in yoga). Next slowly and carefully roll your skull and forehead onto the carpet, using your flat hands by your face for leverage and balance. Rolling your head (skull and forehead) on the ground expands your field of vision, releases any blockages in the neck, base of the skull and the eye muscles. Use it to temporarily “forget the sight of the patient".

4.2 Vocal expression

Confirmation about the healthy effects of activating the body and vocal expression is provided by a study from the Frankfurt Institute for Music Education, entitled: "Singing promotes the immune system! Listening to music, however, does not!"

Researchers from the University of Frankfurt measured the blood values (immunoglobulin A and cortisol) of singers from an amateur choir before and after rehearsals of Mozart's Requiem. Their blood values, regarded as an indicator of the body's immune system, increased after singing. Their subjective mood also changed for the better. A week later, the same study proved that listening to the same Requiem did not positively influence blood values at all (cf.. NOZ 01.17.04, report about Prof. Hans Guenther Bastian from the Frankfurt Institute for Music Education).[3]

In Bioenergetic Analysis, we emphasize the ability of the *body and the voice to express themselves*. We regard the releasing power of vocal expressions of fear, sadness, or anger per se as therapeutically effective - just like the vibration of the muscles (neurogenic tremor). Expressive work with the voice is - in contrast to coordinated singing or silent mindfulness and Yoga exercises - a magnificent permission to be our true self. The shrill squeals, deep sighs, vehement cries, animal roaring, profound sobs, loud voluminous laughter now receive a space and we can massage our voice from within, tonify ourselves, relieve ourselves from any stress and reach out to our social environment with our emotions. We turn our attention to vocal timbre (the emotional coloring), melody (prosody), volume, and the ability to make ourselves noticeable in our surroundings. In this respect, Bioenergetic Analysis is very different from other purely therapeutic body techniques like Yoga (except Laughter Yoga), Tai Chi, Chi Gong, Shiatsu, osteopathy, meditation, focusing, etc. or even purely verbal methods that work with the principles of mindfulness and imagination. To my knowledge, no other psychotherapeutic method works explicitly with the voice. Even psychodrama and Gestalt therapy does not grant the voice the same status as we do in Bioenergetic Analysis.

**Self-care exercises for therapists 2: vocal expression (discharge)**

- Go down on your hands and knees and move your back alternatively into concave ("cow") position and convex ("cat") position. Use this Yoga "cow-cat" exercise with fear being inhaled in the cow-position and relief exhaled in the cat position. Imagine a difficult and scary patient while you look at the ceiling and inhale with a "hhii." Next, imagine that he has exited through your door while you are arching your back like a cat, letting go and exhaling with an "Aah." You may experience a discharge of anxiety with the exaggerated, amplified sound of fear (permission to be afraid) and control over your repugnance and fear by switching between fear and relief. The upper and lower parts of your body become integrated through the wave motion (trust through pelvic breathing) and dissolution of the rigidity held in fear (eyes, mouth, neck, throat, diaphragm.) This paradox often makes room for a lighter and even humorous mood. (The same exercise can also be performed standing where you imagine seeing the face of an unpopular patient on the ceiling.)

[3] Cortisol - a hormone which, for example, has catabolic effects and a dampening effect on the immune system, is widely used in medicine to suppress over-reactions in the body and inhibit inflammation. In this respect, the increased cortisol value after singing can be seen as a significant sign of the body's responsiveness in favor of improved immunity. Immunoglobulin A (IgA) is an antibody that occurs mainly in the external body fluids, where it forms an important defensive barrier against pathogens.

- Try starting laughing while in a standing position. First arch your back (aka arch aka bow) and then bend over (aka forward bend, aka elephant). Laughing is the easiest, most enjoyable and spontanous way to deepen your breathing (explanation of exercises cf. Shapiro 2008, p. 79)
- Imagine you are an idiotic therapist. Stick out your tongue left or right in turns and laugh with joyful, absolutely stupid excitement (ibid, p. 69).

**Case Study Self-Care**

In a self-awareness group, a colleague in training reported about her own insomnia. Out of fear of her first consultation sessions, she could not sleep for two nights and was plagued by doubts about her abilities. She could not sleep once she arrived here in the seminar house (where training occurred) either. In a first body diagnosis of her body posture while standing up, her raised, tense shoulders and the anxious expression in her eyes became apparent. She reports about the "Frozen Shoulder" symptom. In her body-oriented family constellation of the relevant biographical scene, there emerged a picture of her three older brothers bearing down on her shoulders and pushing down on her. They would often frighten and torture her with their antics: she remembers how she went to the outhouse in the dark across the yard when she was 4 years old and, as she sat there alone, how the brothers had turned off the light. She was terrified and screamed. Her parents had not noticed the dirty trick and her plight. Today, as an adult, she reports not being able to scream and feeling imprisoned in her own body when she feels overburdened by excessive demands. While working on this scene, she dares to raise her voice and gradually calls out “Stop it!” with increasing volume until she emits an explosive scream that fills the room. This relaxes her shoulder muscles and her fear-filled eyes as well. The following night she is able to sleep well in the seminar house. Back home, she regularly practices screaming during her trips in the car to her counselling work and reports that she is able to sleep again.

### 4.3 Touching and soothing

Skin contact lowers blood pressure, promotes the interaction of the adrenaline-system ("fight-flight-freeze") to release the hormone oxytocin - the hormone of peace and love (cf. Uvnäs-Moberg 2003). When physical contact is experienced in a safe manner within a relationship, this will, in terms of neuroception, stimulate the "intelligent" ventral vagus (VVC) most likely via the oxytocin mechanism and, along with facial expressions and emotional exchange, prosocial behavior as well (cf. Porges 2010; Clauer, 2013, p 152f ).

In my opinion, the difference between Bioenergetic Analysis (and other body psycho-therapies that work with relationships) and pure body therapies, such as massage, physiotherapy, osteopathy, Yoga, etc., is that it is defined by relationship-building, rhythmically coordinated gestures, or physical contact connected to relationship images, that stimulate other responses via the vagus than mere mechanical contact from a strange person.

This specificity of a trustful physical contact within a trusting human relationship has not been adequately studied in neurobiological, ethologically oriented research.

By touching our patients, practicing different hands-on techniques and types of contact (such as sitting back to back, pressing our hands and feet against each other, holding them, "dancing" with them), we are touched by them and thus encounter a feedback effect. This means that our VVC is stimulated during our bioenergetic work.

Physical contact is salubrious and absolutely necessary for psychotherapists! Especially when working with an abstinent touch when physically contacting our patients, it is all the more necessary that we ourselves are sufficiently hugged in our own private lives and lovingly maintain a fulfilling sex life.

**Self-care exercises for therapists 3: body contact partner exercises for at home**

- Lie supine (face up) on the back of your partner who is lying prone (face down) on a mattress. Use this for safe partner grounding. Relax and breathe slowly.
- Sit across from your partner and, place your feet on your partner's feet to support each other in grounding.
- Go into the Bow (aka Arch) position. Have your arms above the elbows held by your partner to get a slow expanding stretch in your the chest muscles (aka "open wings"). Lean forward as your partner pulls your arms back slowly and carefully.
- Next, have your partner tap your back with hands while you are bent over in the elephant position.
- Next, as you drop your head, have your partner give you a neck massage, while you are in the elephant position.
- Standing back to back with your partner. Both of you start pushing the other across the room with all strength you have in your pelvis/buttocks. Offer some resistance to your partner using your voice as well. Imagine a place where you want your partner to get to. Stand across from each other. To feel your boundaries, place your hands on your partner's hip bones and slowly push them across the room, while they offer some resistance as they walk backwards across the room.

4.4 Resilience and vitality as a physical concept

- **INSERT Here Fig.** "The change starts within the therapist" (paraphrased from Christopher Bollas 1989)

Surely, this statement is similar to that expressed by C.G. Jung - regarding emotional and mental infection and the corresponding inner self-healing attempts by the therapist. In Bioenergetic Analysis, we have a bodily understanding of the "infection" and the "self-healing attempts": "The personality of an individual cannot change as long as no corresponding change in his physical dynamics takes place" (cf. Lowen ?).

Of course this also applies to us therapists. And our special responsibility is primarily to only apply those interventions that we have also experienced and learned ourselves (cf. Pechtl

1980, p.196) and, I would like to add, only those that we are ourselves are willing to continue to practice. (cf. Schroeter/Thomson 2011).

"It is therefore essential in my eyes to know the different areas of your own body space in the form of emotional vibrational ability in perception and physical activity, emotional expressiveness or blockage." (cf. Oelmann 2009, p 66).

The strength *to set boundaries* is a skill that is not primarily directed against others but is available for yourself: a joyful "No" to a transgression of your boundaries is an important task!

Depression beckons the exhausted therapist, since breathing is often reduced or a reduced respiration is a result of the attempt not to feel so much and to protect himself from the patient's feelings. The ability to set a boundary not only depends on the awareness of your own muscular strength but largely on your ability to breathe deeply. As a result, the body develops resiliency and toning, as the thoracic spine straightens up when inhaling. This way we send nonverbal signals that demonstrate that we are in full possession of our strength and that we do give ourselves inner space. The more clearly do we then non-verbally show our counterpart this personal space and the limits of our contact. Others have less of a chance to penetrate us when we fill ourselves sufficiently (with breath). When our speech is full of breath our voice communicates that we are sure of ourselves. This self-conviction acts as a contact boundary. This does not even require any sort of confrontation or struggle even. Sometimes merely a deep sigh or a direct statement are enough to say that it is too much for us.

We can develop this contact boundary by employing bioenergetic *exercises for our breath and our voice* for our daily "hygiene."

**Self-care exercises for therapists 4: vocal expression, charging and boundary-building**

- As you exhale, emit a strong "hah!" sound in different variations (loud-quiet, short-long). We may use internal images or imagine scaring someone (perhaps a patient). We can keep other people at bay with our voice. Or we can simply project the sound to the nearest wall or send it to the ceiling (which relaxes the diaphragm)
- Experiment with consonants that give a sense of boundaries and incisiveness, such as: "... SSSShh ..." - "Pppah" "KKah" "Ttth" (emitted loudly)
- Imagine a domineering patient. Stretch your arm out, pointing your index finger in your imagination towards the person, proclaiming: "You need to do it the way I want it!" Or: "I will have the last word!"
- Lying on your belly on a mattress – tense the muscles in your back, arms and legs to their maximum, tone up your voice, draw it in and hold, exclaiming: "I caaaaaann!" Stop at the top (peak) of self-control! This energizes, invigorates and warms you. It promotes a feeling of self-efficacy. It involves toning the muscles instead of stretching and releasing. This feels containing rather than discharging. (cf. Shapiro 2006)

Exercises for grounding and expressive work with aggressive impulses can help us to not retain the representative anger and indignation in us that may result from our therapeutic

contact. Bioenergetic techniques, like hitting something with a tennis racket, kicking the mattress while lying down, using the teething ring and growling, etc., can help us in this regard. By releasing the muscles in our abdomen, back and legs, combined with vocal expression, we make contact with our own emotionality and take our protest seriously in order to invigorate ourselves again.

By directing our attention to the hidden aggressive charge behind an exhaustion depression and by permitting an energizing of our anger within a safe framework - instead of simply regulating ourselves down via soothing, regressive and avoidance-related activities - we act invigoratingly, move out of our resignation and organize our emotional movement patterns anew. This positive orientation or appreciation of our aggressive impulses - even those of resentment - gives us a chance to remain in contact with ourselves and others in a constructive manner. Here Bioenergetic Analysis has an aspect of self-care that cannot be appreciated enough, which is also consistent with the results from emotion research (cf. Koemeda 2006).

**Self-care exercises for therapists 5: resistance**

- Tap your sternum stimulating the thymus gland, proclaiming: "Me first!" (reduces altruistic mode).
- Stretch your arms upwards and then turn to the side imagining being able to feel the air's resistance and pushing against it.
- Stand in the doorway pressing against the resistance of the wood with extended palms when exhaling.
- Press palms of your hands against each other (cf. Shapiro 2008, 2009)
- Lie on your back pushing the air with your legs while exhaling, toes towards your face, heels towards the ceiling. Imagine pushing someone away.
- Lie on your back kicking your legs into the air yelling: "Beat it!"(think of last weeks patients) - while letting your buttocks bounce on the floor.
- Assume the elephant position, leaning into the wall or a cube.
- Push against the cube with your neck and upper back while exhaling and exclaiming: "Nooooo!" with a rising voice.
- Stamp your feet, saying: "I do not want to please you!". Next, thrust jaw out and place hands in a defensive position. Push your elbows behind your back, yelling: "Beat it!" (Imagine your most annoying patients)
- Exercise self-control during the classic bioenergetic exercises, which are not used here to discharge stress but to contain your strength: kick a cube or lie down and kick on a mat 10 times and hit down hard with your arms 10 times. Do stop before getting exhausted! Stop when you feel you are in control of your anger.
- Go over the Breathing stool (not as trained into the surrender position but holding your head up looking straight forward!). Push your lower jaw forward and thrust your pelvis forward while exhaling.

- **INSERT Here Fig.** "Better some rigidity than being flooded" (Stanley Keleman)

I regard this statement by Stanley Keleman (2008) as an indication of the health-maintaining function of "rigid" bioenergetic procedures in the therapeutic process. The statement was certainly meant in terms of patients. However, from a self-caring perspective, it applies just as

well to us therapists. Rigid therapists (according to the character structure analysis of Lowen) do not allow any heart-felt feelings for their patients. Instead, a sober and factual, non-erotic approach prevails in matters of love and sexuality. They also have more "structure" (emotional control) than so-called pre-oedipal characters. The fact that the "empathic dilemma" (mutual consternation and collusion) may be limited in their therapeutic encounter – with its focus on cooperation and ritualized exercises – may be regarded as a positive aspect of the rigid therapist. Repetitions and directive, ritualized bioenergetic techniques and exercises based on tangible objects and technical aids represent a protection for us therapists in the context of our risk of being flooded with emotions!

Work, however, is no problem for the rigid character. To save the rigid therapist from an exclusively technique-based orientation, playful activity and an opening of her heart would be important (Shapiro 1993, 2008, 2009)!

SUMMARY

This article has argued the importance of the empathic and resonating body of psychotherapists – and it´s other side of the coin (or shady or flip side?). It focuses on the value of using the motility of the body itself in self-care for body-psychotherapists. Bioenergetic exercises are provided to help the therapist recover from the effects of negative experiences with difficult patients. Many exercises are included for grounding and expression of negativity and containment (setting boundaries) to enhance the ongoing health of the practicing therapist.

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